# WELLNESS PROGRAM
# PARTICIPANT CONSENT FORM

I am being asked to read the following material to ensure that I am informed of the nature of this program and of how I will participate in it, if I consent to do so. Signing this form will indicate that I have been so informed and that I give my consent. Federal regulations require written informed consent prior to participation in this program so that I can know the nature and risks of my participation and can decide to participate or not participate in a free and informed manner.

**PURPOSE**
This is a voluntarily Wellness Program for Department of _____ employees. The program will consist of activities to increase your physical activity. The goal of this project is to increase the level of physical activity of employees through activities such as walking for 30 minutes a day.

**PRODEDURE**
Participation will mainly consist of involving yourself in daily physical activities. Specifically, you will be asked to walk or engage in some other physical activity for *three (3) hours a week or thirteen (13) hours a month for six (6) months* and to keep a weekly log of this activity. Finally, you will be asked to complete one pre-test concerning your level of physical activity and your impressions of the program.

Additionally, you can contact the wellness coordinator *(name and number)* to answer questions about the program and to help you participate in program activities.

**Please remember that your participation in this program is strictly voluntary and that you are free to discontinue you participation at any time without repercussions affecting your employment or benefits.**

**RISKS**
The risks of participating in this program should be minimal for most participants as all you will be asked to do is slowly increase your physical activity through walking or other physical activity, and complete a pretest and posttest survey. **However, as with any physical activity program we recommend that you consult with your personal healthcare provider if you have not participated in a physical activity program for some time (e.g., 2-3 years); or if you have been diagnosed with any of the following: cardiovascular disease, cancer (recently and are taking chemotherapy), lung disease such as COPD or asthma, diabetes, hypertension, rheumatoid arthritis, or are taking any immunosuppressant medication.**

**BENEFITS**
The main benefit of participation in this program is to increase your physical activity and knowledge of wellness issues. Additional benefits **may** include increased cardiovascular health, weight loss, and stress reduction.

**CONFIDENTIALITY**
While we need your name on a sign up sheet, the data you provide will remain confidential. Your name and wellness information will remain confidential and will not be used in any data analysis or published in any manner.

**COSTS AND COMPENSATION**
Your participation in this program is free. There will be no charge to join or participate in any of the activities. Individuals, who engage in activity for *three (3) hours a week or thirteen (13) hours a month for six (6) months,* will be rewarded with no more than *one day of administrative leave or other incentive items.*

**LIABILITY**
Complications or harm are possible in any physical activity despite the use of high standards of care and could occur through no fault of yours or the committee involved. State workers compensation

insurance covers all employees while on state property. It does not cover employees once they leave state property; therefore, you will be asked to sign a liability waiver if you plan to participate in any physical activity off of or away from state property. Please understand that you do not give up any of your legal rights by signing this form. If you have any questions as to your participation in this program, please contact, (name and number of contact person)

**AUTHORIZATION**

BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE PURPOSE, PROCEDURES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME, AND MY QUESTIONS HAVE BEEN ANSWERED. I MAY ASK QUESTIONS AT ANY TIME, AND I AM FREE TO WITHDRAW FROM THE PROGRAM AT ANY TIME WITHOUT REPERCUSSIONS EFFECTING SUBSEQUENT MEDICAL CARE. MY PARTICIPATION IN THIS PROGRAM MAY BE ENDED BY THE COMMITTEE FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS PROGRAM, WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THE PROGRAM, WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE. I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME IF REQUESTED.

*By signing this form I hereby give permission to the Department of _____ to use the information provided by me in their data analyses to assist in the development of a program designed to increase physical activity and wellness among Department of _____ employees.*

_____ _____

Subject's Signature Date

**WELLNESS PROGRAM COORDINATOR**

The nature of the above project has been explained to the above participant. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. It is also my understanding that a medical problem or language or educational barrier has not precluded this understanding.

_____ _____

Signature of Manager Date